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HOUSE BILL 2044
By Davis

AN ACT to amend Tennessee Code Annotated, Title 56 and Title 71, relative to the provision of certain health care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as new, appropriately designated sections:

Section ___. (a) For purposes of this act the term "managed care organization" includes health maintenance organization and preferred provided organization.

(b) If a managed care organization includes home health agencies in its network or plan, then such organization may not exclude any or discriminate between home health agencies which are certified by Medicare and licensed by the state if such home health agency has expressed a desire to be included in the network or plan.

Section ___. (a) Each managed care organization operating in this state shall use a uniform set of standards to determine a patient's qualifications as a home health patient, including but not limited to, prior approval and admission criteria, pre-certification requirements, covered and non-covered supplies, and projected number of visits per diagnosis. Such organizations shall be required to use standardized forms for all reports which must be submitted by the medical personnel providing the services to the patients.

(b) The commissioner of commerce and insurance shall develop the uniform standards, forms and criteria for use by each managed care organization.

Section ___. (a) If a managed care organization denies an enrollee's request for coverage, the managed care organization shall offer the health care provider or the

enrollee the opportunity to have the requested service expeditiously reviewed by at least two (2) independent medical experts. These experts shall be physicians or other health care providers who are specialists in the treatment of the enrollee's condition and knowledgeable about the treatment recommended for the enrollee. The managed care organization shall not choose or control the choice of the experts, but shall contract with an impartial independent entity to select the experts and arrange for them to give their opinions.

(b) The independent medical experts shall give their professional opinion on whether the requested treatment has reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee who has requested coverage for the treatment under review. Opinions shall be in written form and include, but not be limited to, the following:

(1) A description of the individual enrollee‘s condition who has requested coverage for the treatment under review;

(2) A description of indicators relevant to determining whether the requested treatment has reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee who has requested coverage for the treatment under review;

(3) A description and analysis of any relevant findings published in peer-reviewed medical or scientific literature; and

(4) A description of such enrollee's suitability to receive treatment according to a treatment protocol in a clinical trial, if applicable.

(c) Managed care organizations shall provide to the independent medical experts a complete copy of the medical record of the enrollee who has requested coverage for the treatment under review. The managed care organization shall notify both the individual enrollee and the treating health care provider of the names of the independent reviewers.

(d) Neither the experts nor the entity arranging for the experts' opinions shall have any professional, familial, or financial affiliation with the managed care organization, except that the managed care organization may pay for the expert opinions. The experts shall have no patient/physician relationship or other affiliation with the specific person whose care is under review. The enrollee shall not be required to pay for independent reviewers' opinions.

(e) The review shall be required to be completed within thirty (30) days of the request, except that if the health care provider treating the enrollee whose treatment is under review states that the requested treatment would be significantly less effective if not promptly initiated, the review shall be completed within five (5) days of the request.

(f) If a majority of the independent reviewers determine that the treatment sought by the enrollee has a reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee who has requested coverage for the treatment under review, then the managed care organization shall authorize and pay for the treatment. If the independent reviewers are evenly divided in their determinations, then the managed care organization shall authorize and pay for the treatment. If less than one-half (1/2) of the independent reviewers determine that the treatment sought by the enrollee has a reasonable likelihood of producing a clinically meaningful benefit for and is reasonably unlikely to produce harm to the individual enrollee who has requested coverage for the treatment under review, then the managed care organization may continue to decline authorization and payment for that treatment.

(g) In any court action based on a denial of coverage, compliance with the review process set forth in this section shall create a rebuttable presumption that a coverage determination made pursuant to the review process was reasonable.

SECTION 2. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following language as a new, appropriately designated section:

Section ___. Notwithstanding any other provision of law to the contrary, all reimbursement rates for providers and all benefits offered by every managed care organization providing health care to TennCare recipients or enrollees shall be set by the TennCare bureau in a manner to ensure that all rates and benefits are equal and uniform among all such managed care organizations.

SECTION 3. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 1996, and shall apply to all plans to which this act applies entered into or renewed on or after the effective date.